CITY OF WEST LAFAYETTE
FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please Read These Instructions Before Completing the FSA Withdrawal Request
1. Employee must complete **Part 1**. (If applicable, complete Part 2 Health Care Expenses and/or Part 3 Dependent Care Expenses.)
2. Instructions for **Part 2**: A. If expenses were covered by any benefit plan, attach a **copy** of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or spouse's carrier or any individual plan) should pay before you request an FSA reimbursement. B. If expenses are not covered by any benefit plan, attach a **copy** of an itemized receipt that includes the dates of service, service rendered, and total charge.
3. Instructions for **Part 3**: Attach a **copy** of a receipt that includes the dates of service, day care provider's name, and amount paid to day care provider or attach a **copy** of a cancelled check from the day care provider.
4. Read the Certification For Reimbursement, **sign and date the form**. Make a **copy** for your records.
5. Mail the form to the address provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

PART 1 EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (Last and First	Social Security Number	DATE OF BIRTH	DAYTIME PHONE NO.
		/ /	( ) -
EMPLOYEE ADDRESS		CITY, STATE, ZIP	

PART 2 HEALTH CARE EXPENSES (Please Print) Please place each expense on a separate line

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICES **Please check the appropriate box below for each expense(s)** MD=medical RX=prescription VS=vision DN=dental HR=hearing	**REQUEST AMOUNT**
	FROM:	**TO:**	**MD___ RX___ VS___ DN___ HR___ Other________**	
	FROM:	**TO:**	**MD___ RX___ VS___ DN___ HR___ Other________**	
	FROM:	**TO:**	**MD___ RX___ VS___ DN___ HR___ Other________**	
	FROM:	**TO:**	**MD___ RX___ VS___ DN___ HR___ Other________**	
			HEALTH CARE EXPENSE SUBTOTAL	$

PART 3 DEPENDENT CARE EXPENSES (Please Print) Please place each expense on a separate line

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICE(S)	REQUEST AMOUNT
		FROM:	**TO:**		
		FROM:	**TO:**		
				DEPENDENT CARE EXPENSES SUBTOTAL	**$**

TOTAL REQUEST FOR WITHDRAWAL	**$**

CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or/we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) income tax return.

EMPLOYEE SIGNATURE: **DATE:**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

CITY OF WEST LAFAYETTE
FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please complete the information on the other side of this page and review the following reminders to ensure accurate and timely processing of your request:

- Is your participant ID number included on the form?
- Is your total requested amount included on the form?
- Did you attach copies of your itemized documentation with your request?
- Did you sign and date the bottom of this form?
- Have you made copies of your request for your own personal records?

The following examples are eligible for reimbursement through the Health Care Spending Account:

- ✓ Acupuncture
- ✓ Chiropractic services
- ✓ Coinsurance/Copays
- ✓ Contact lenses and solutions
- ✓ Deductibles
- ✓ Dental Expenses
- ✓ Dentures
- ✓ Diabetic supplies
- ✓ Guide dogs
- ✓ Hearing aids/batteries
- ✓ Laboratory Fees
- ✓ Laser eye surgery
- ✓ Childbirth expenses
- ✓ Orthodontia
- ✓ Pediatric services
- ✓ Prescription drugs
- ✓ Psychological treatment
- ✓ Speech therapy
- ✓ Surgical fees
- ✓ Transportation fees necessary for medical treatment
- ✓ Vaccinations
- ✓ Vision expenses

The following examples are ineligible for reimbursement through the Health Care Spending Account:

- ✓ Cosmetic procedures and supplies
- ✓ Marriage/family counseling
- ✓ Amount reimbursable through another benefits plan
- ✓ Weight reduction programs for general health
- ✓ Premium payments for health, dental, or vision care coverage

The following examples are eligible for reimbursement through the Dependent Care Spending Account:

- ✓ Care for a dependent under the age of thirteen or a qualified individual incapable of self-care
- ✓ Licensed nursery school
- ✓ Adult day care facilities
- ✓ Qualified child care centers
- ✓ After school programs

The following examples are ineligible for reimbursement through the Dependent Care Spending Account:

- ✓ Sleep away overnight camps
- ✓ Tuition fees for private or boarding homes
- ✓ 24-hour nursing home care
- ✓ Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work
- ✓ Care provided for your child by a sibling under the age of 19 or someone you claim as a dependent on your income tax return
- ✓ Expenses for which you claim a tax credit on your federal tax income return

The above are some examples for eligible/ineligible expenses that can currently be reimbursed through Flexible Spending Account. If you have any expense that is in question, please feel free to contact the Administrator's Office at 800-552-6550.

Claims are to be filed to the following address:

City of West Lafayette Flexible Spending Account
Claims Administrator
P.O. Box 5769
Lafayette, IN 47903-5769